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VA Making Amerika great again.
Do we kill 'em and how!

Another Veteran Suicide In Front Of VA Emergency Department

3 minutes

Reports have now floated across the blogosphere that another veteran suicide by gun occurred recently in front of the Amarillo VA, located in Texas.

At the end of last month, one veteran committed suicide in front of the Thomas E. Creek VA Medical Center on a Wednesday morning. One of my readers messaged me yesterday and asked me to highlight the veteran's suicide that likely was the result of poor or mismanaged mental health care at the facility.

The Amarillo Police Department was called to the VA Medical Center at 6010 W. Amarillo Blvd. shortly after 7 a.m. to find a man, whose name has not been released. That man was dead from a self-inflicted gunshot wound.

Veteran Suicide Statement

"This morning, a veteran took his life in the front of the main hospital of the Thomas E. Creek VA Medical Center," Barbara Moore, Chief of Community and Patient Services at the VA hospital, said in a statement.

"In order to protect the veteran's privacy, we are not able to share any additional details. Our deepest condolences are extended to friends and family of the veteran. We are cooperating with local authorities on the investigation."

Is silence what the veteran wanted? Is VA truly trying to protect the dead veteran's suicide or are they trying to cover up the epidemic of veteran suicides nationwide?

Remember Albuquerque?

This is essentially the same song and dance Albuquerque VA gave me after I inquired into a similar suicide outside that medical facility.

Only there, Albuquerque police claimed they were not involved in investigating or responding to the incident, citing the facility was on federal property. Apparently, the agency's ability to keep things quiet depends on the state that facility is in.

RELATED: Media Blackout Of Bloody Veteran Suicide At Albuquerque VA

The VA spokesperson said according to the latest statistics from the VA, approximately 20 veterans commit suicide each day, and six are in some type of VA care program.

VA has been unable to make a substantive dent in the number of daily veteran suicides despite record funding and research into the crisis since the start of the Iraq War.

RELATED: No Media For Veteran Suicide Linked To Minneapolis VA Care

"We urge veterans experiencing a crisis, as well as their family members, to contact the Veterans Crisis Line at 800-273-8255 (press 1)," Moore wrote. "This line is available 24 hours a day, seven days a week."

Source: https://amarillo.com/local-news/news/2017-07-26/veteran-commits-suicide-front-amarillo-va-hospital

amarillo.com

Veteran commits suicide in front of Amarillo VA hospital

Ronald Balaskovitz
3 minutes

Wednesday

Posted Jul 26, 2017 at 3:28 PM

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Troubled Iowa veteran sought help from VA hospital before freezing to death | CNN

Jake Tapper, Kim Berryman and Glen Dacy, CNN

10-13 minutes

Story highlights

Iraq War veteran Richard Miles sought help at VA hospital in Des Moines, Iowa

Miles went to hospital for help; doctor's notes indicate Miles said he was not a danger to himself

Days after being sent home, Miles was found dead in the woods

Des Moines, Iowa CNN —

“I need help.”

On February 15, Iraq War veteran Richard Miles entered a U.S. Department of Veterans Affairs hospital in Des Moines, Iowa, and told the staff: “I need help,” according to hospital records obtained by CNN.

He had told friends he was going to check himself in. He was diagnosed with “worsened PTSD,” anxiety and insomnia, but Miles was not admitted to the hospital.

Five days later the 40-year-old father was found dead in the woods, having taken a toxic amount of sleeping pills, according to a toxicology report obtained by CNN. He died from exposure to the elements.

Now those who loved him want to know why the VA hospital did not admit him when he showed up that night.

“That was his cry for help and it was not taken seriously or received the way it should have been received,” said Katie Hopper, his ex-girlfriend and mother to their daughter Emmalynn.

Miles was one of the premiere presenters at the Science Center of Iowa, a beloved employee popular with the staff and guests.

“He was passionate and knowledgeable about science himself and it went beyond that. His passion extended to sharing that knowledge with others,” said Science Center of Iowa President and CEO Curt Simmons. Miles’ image was featured prominently in YouTube videos and advertisements for the museum; a large photograph bearing his image stands outside the center.

What this popular Iraq war veteran did not share with most, is that he suffered from post-traumatic stress disorder, or PTSD.

“He knew the date, and where he was when he had shot and killed people in the war,” says Hopper. “He was very, very aware of what he was doing, that he was ending people’s lives, even if it was for the greater good.” The memory of an interrogation incident with a frail, old Iraqi man upset him quite a bit, she recalled.

Medical records obtained by CNN state that after Miles returned from Iraq in 2004, he “began to experience depression with suicidal attempts.” He recalled seeing dead bodies, and often had graphic, violent dreams.

One record from 2011 says Miles “described onset of anger, outburst and irritability beginning after his return from deployment in Iraq during October 2004.” He “recalled his war related experiences about ‘being on alert and seeing dead bodies.’ He further noted sleep disturbance with troublesome dreams ‘about combat and military-related content.’”

Miles had “many dreams about death and violence,” the records state. “The dreams are graphic and often involve themes of needing to protect someone, and an outcome of killing someone in the course of protecting someone else. Mr. Miles awakens from the dreams anxious and sad. This occurs 2-3 times per week.”

Friends and family saw Miles struggle with his PTSD, but say he was doing generally fine until January, when he disappeared. A missing person report was filed with local law enforcement.

He finally responded days later to friends such as Harry Aller, who had sent Miles text messages.

“He wrote back … ‘I didn’t mean to get people worried I just need to spend some time at the hospital to figure things out,’” Aller said.

Thankfully, Miles returned, and chose to stay with Hopper.

[this guy intended to suicide; he learned telling people would not get him help only ridicule, intimidation and worse out of VA and healthcare providers whose incompetence cannot help him. He kept everyone else calm while coming apart inside seeking death to quell his pain. VA only hears what it wished nothing more...another suicide and those behind remain clueless]

"I said do you feel like you need to get out of the house, do you want to go for a drive, do you want to go for a walk? He said, ' No, I'm going to go to the VA.' Right now? 'Yeah, right now,'" Hopper said.

"He had to be of in a place [he was already there] where he was going to harm himself, mentally. And the thought of that would lead him to want to get help because he would be letting down his daughter, his son, his friends, and that was not an option for him," said Aller.

On February 15, Miles left several of his belongings with Hopper and went to the hospital. It was a familiar place to the veteran whose medical records show a long history of [ignored] suicidal acts and thoughts.

He'd been hospitalized at the Iowa VA hospital four times for PTSD between 2008 and 2009, after he "made 2 attempts to hang himself," according to records. At one point he had brought a gun into a different hospital ward planning to kill himself.

Records show friends called the VA to look for him and later filed a missing persons report with local law enforcement.

Files from that day show Miles told the hospital attendant he needed help. When the attending doctor asked him whether he was a danger to himself, Miles responded, "No, I won't harm myself, but I do need some medicine so I can just rest, [**forever**]" according to the notes.

"He came home about three hours later," said Hopper, who was surprised at the quick return. "I thought you were going to be days or weeks even," she recalled saying to him.

"He said, 'Yeah, me too, but they just gave me medication and sent me home, said my psychiatrist would follow up with me this week to set up an appointment,'" she said.

Miles did not make it that long. A few days later, after giving Emmalynn a big hug goodbye, he instead walked into the woods – where he and Hopper used to go – and never came back.

The toxicology report shows Miles had ingested a toxic but not fatal number number of lorazepam sleeping pills, which he had been prescribed just a few days before at the VA, and froze to death.

His was found with no jacket, no shoes, and most infuriatingly, no clear reason why his life had to end like this. [you clueless idiots! Pain that is why!! VA failure to address and help veterans only self]

"The VA failed him. They failed him," said Hopper.

[if this is true and not CYA standard VA procedure] Emergency room staff "followed proper mental health screening procedures and then scheduled an outpatient psychotherapy appointment for seven days from that point," the Department of Veterans Affairs said in a statement to CNN, adding that Miles

was “given anxiety and insomnia medication upon his departure from the emergency room – medication he indicated had helped him in the past.”

CNN provided the more than 1,200 pages of Miles’ records to Dr. Elspeth Cameron Ritchie, a longtime Army psychiatrist and former chief clinical officer for the District of Columbia’s Department of Mental Health. She’s now retired from the Army.

[the wishy washy statement] “This seems like it was a very tough situation,” Ritchie said. “In retrospect – and this happens very commonly after a suicide – you look back and you look back and **you see all kinds of red flags** or information that one person knew but another person didn’t know, and if you put it all together, yes, maybe he should have been hospitalized.”

But, Ritchie added, “my reading of it is that the emergency room physician didn’t have that information and that he denied feeling suicidal, and that’s really tough for psychiatrists. We can’t read people’s minds we can only look at the information available and make a judgment.” [in other words these people are clueless]

CNN asked Ritchie, is it not enough that he had tried suicide before and that he had had a missing person report filed for him in recent days?

“Again, in retrospect, perhaps we would have done things differently but his suicide attempts were back in ‘08 and ‘09. This was 2015. I don’t know that the physician knew about the missing person report, and we weren’t there at the time to see what actually happened. That’s one of the challenges with looking at medical records afterward and why it’s so important to do good documentation,” he said. [the old soft shoe denial, willful denial, plausible deniability.]

If proper procedures were indeed followed, are VA procedures in dealing with suicidal veterans adequate? [no] Brandon Coleman says they are not. Coleman developed a suicide prevention program at the VA hospital in Phoenix, where he says it’s desperately needed. **Now the disabled Marine Corps veteran says he’s blowing the whistle on insufficient care for his peers.**

“We’re missing the boat with these most at-risk veterans, and not enough is being done systemically in order to protect them. … We can’t just hand these guys pills, (that) is not the answer,” said Coleman.

“I came forward mainly because of the veteran suicides. They’re not being handled properly,” Coleman told CNN.

In December 2014 he told the Office of Special Counsel – an independent office assigned to protect whistle blowers – that suicidal veterans “are not properly monitored at the Phoenix VA and oftentimes they leave after being deemed suicidal because they are not properly watched by trained professionals.” ***When Coleman tried to discuss issues with the care of suicidal veterans to his supervisors they “always fell on deaf ears.”***

On January 23, another concerned employee at the Phoenix VA secretly recorded a staff meeting, where officials discussed that suicidal veterans there had “bolted out the door.” [what caused them to do that?]

“It has been a high number like five in the last week,” emergency room staff is heard saying on the recording.

“We have been really lucky that nothing bad has happened in these instances where vets have split. It was sheer luck that nothing happened,” a supervisor says.

Coleman is now nearing his second month of paid administrative leave, retaliation for being a whistleblower, he says.

[the official party disclaimer] In a statement to CNN, the Phoenix VA said “we have strengthened our protocols and approaches for how we care for suicidal veterans … we continue to look for ways improve the care and appreciate suggestions made by our employees and others.”

It is a different VA, but part of the same troubled system. A 2012 VA report suggests about 22 veterans commit suicide each day.

Some of them sought help at VA centers and other hospitals and didn’t get the treatment they needed.

“I think the VA is in the lead on treatment of PTSD. Are they doing as much as they could be? It’s no secret that the VA is an overwhelmed system,” said Ritchie. “And it’s no secret to anybody that the **VA can’t handle it** all.”

The friends and family of Richard Miles want the VA to learn from their tragedy. They want the VA to figure out what they could have done differently with Miles, so the next veteran is admitted and helped.

“I don’t have a friend. My daughter doesn’t have a father. He touched so many people, he was so great. He was such an inspiration,” Hopper said, crying. “**I really do feel as though the VA failed him, and ultimately I feel it’s kind of on them.”**

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Veterans Twice As Likely To Commit Suicide Says New VA Study On Veteran Suicide

7-8 minutes

A new Veterans Affairs report with updated statistics on veteran suicide shows veteran suicide numbers are significantly higher than non-veterans and not going down despite tens of millions in spending.

The report, VA National Suicide Data Report, shows veterans aged 18-34 have a suicide rate more than twice as high than non-veterans. The numbers published cover 2005-2015 and contain data not previously published in the agency’s rushed 2016 report.

While the agency asserts veteran suicide has remained static at 20 deaths per day, the newer numbers show the agency's spending to reduce suicide has only benefited the government contractors and not the veterans targeted with the resources created.

RELATED: Veteran Commits Suicide By Fire

Who would have thought suicidal veterans would not pay much attention to fancy websites and advertisements about how great VA is at addressing veteran suicide.

RELATED: New Veteran Suicide Prevention Rollout

In 2016, the agency published new numbers that were reportedly more accurate than previous research showing veterans commit suicide at a rate of 22 per day. That number became a tagline for those who believe VA does not care about veteran suicide.

Using then newly calibrated statistics [SKEWED AND COOKED NUMBERS], VA was able to assert the number of suicides was actually 20, not 22.

So, with this new report, the agency asserts the overall number is still 20 per day, but individual breakdowns show the suicide rate is going up – – and it is going up faster than non-veterans despite record funding and VA supposedly.

RELATED: Veteran Suicide On The Rise (2012)

Suicide Report Executive Summary

Below in italics is the executive summary from the report:

This report provides information on suicide mortality for the years 2005–2015. It incorporates the most recent mortality data from the joint VA/DoD Joint Suicide Data Repository and includes information for deaths from suicide among all known Veterans of U.S. military service. Data for the joint VA/DoD Suicide Data Repository were obtained from the National Center for Health Statistics' National Death Index (NDI) through collaboration a with the DoD. Data available from the NDI include reports of mortality submitted from vital statistics systems in all 50 U.S. states, Washington, D.C., and Puerto Rico.

This report builds upon prior analyses of Veteran suicide and provides additional and updated information on all known suicides among Veterans living in the United States from 2005 to 2015. Findings include direct comparisons of Veterans' suicide rates with those of analogous non-Veteran populations, calculations of suicide rates among high-risk subgroups (e.g., Veterans diagnosed with mental health and opioid use disorders), and comparisons of Veterans with and without recent receipt of VHA services. Rates of suicide were calculated by calendar year to facilitate comparison with national statistics and reports from other agencies.

Please note that this report includes data on suicide deaths through 2015 that were not available at the time of the 2016 report. It also incorporates data obtained from the DoD that were unavailable for previous reports. These additional mortality data distinguish Veterans with likely Title 38 status, meaning potential full eligibility for VA care, from those who were active-duty Service members or who

were National Guardsmen or Reservists never federally activated at the time of their death. Of note, all of these populations, as well as former Service members, are included as Veterans in this report. These additional data are included for the years 2005–2015 in this report's calculations of the number of Veterans who died by suicide each day. All other findings in the report refer specifically to Veterans who had been activated for federal service and were not currently serving on active duty at the time of their death.

Findings are based on analyses conducted by the VISN 2 Center of Excellence for Suicide Prevention and the VA Serious Mental Illness Treatment Resource and Evaluation Center in the Office of Mental Health and Suicide Prevention. Results were obtained using all available information to identify Veterans who died by suicide.

Key findings include the following:

- *Overall, general trends in Veteran suicide, previously reported through 2014, remained consistent through 2015.*
- *In 2015, Veterans accounted for 14.3 percent of all deaths by suicide among U.S. adults and constituted 8.3 percent of the U.S. adult population (ages 18 and up). In 2010, Veterans accounted for 16.5 percent of all deaths by suicide and represented 9.6 percent of the U.S. adult population.*
- *The burden of suicide resulting from firearm injuries remains high among Veterans. In 2015, the percent of suicide deaths that involved firearms remained unchanged from 2014 at 67.0 percent.*
- *After adjusting for differences in age, the rate of suicide in 2015 was 2.1 times higher among Veterans compared with non-Veteran adults.*
- *After adjusting for differences in age, the rate of suicide in 2015 was 1.3 times higher among male Veterans compared with non-Veteran adult men.*
- *After adjusting for differences in age, the rate of suicide in 2015 was 2.0 times higher among female Veterans compared with non-Veteran adult women.*
- *In 2015, rates of suicide were highest among younger Veterans (ages 18–34) and lowest among older Veterans (ages 55 and older). However, Veterans ages 55 and older accounted for 58.1 percent of all Veteran suicide deaths in 2015.*
- *In 2015, an average of 20.6 active-duty Service members, non-activated Guard or Reserve members, and other Veterans died by suicide each day. 6.1 of these were Veterans who had recently used VHA services.*
- *After adjusting for age, suicide rates increased for Veteran and non-Veteran populations from 2005 to 2015. However, rates for Veterans who did not receive care in the VHA increased faster among VHA using Veterans.*
- *Considering unadjusted and age-adjusted rates for 2015, Veterans who had recently used VHA services had higher rates of death by suicide when compared with non-VHA-using Veterans, overall Veterans, and non-Veterans. This is similar to information presented in the previous report and is consistent with findings reported elsewhere. VHA-using Veterans are a population that has active health and mental health care needs and that is actively seeking care because those problems are causing disruption in their lives. Many of these illnesses, such as mental health or substance use disorders, are associated with an increased risk of suicide.*

Full Veteran Suicide Report

[documentcloud url="https://www.documentcloud.org/documents/4522410-180618-OMHSP-National-Suicide-Data-Report-2005.html" responsive=true]

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REPORT: Veteran Charles Ingram Suicide By Fire Linked To Massive VA Fails

10-12 minutes

Photo at Atlantic County CBOC of Charles Ingram burn site.

Northfield, NJ – VA OIG finally issued its report on the death of the veteran Charles Ingram, a veteran who lit himself on fire and later died.

Ingram, a veteran from Egg Harbor Township, engaged in self-immolation by dowsing himself with gasoline and then lighting himself on fire on one Saturday, in March 2016, in front of the Atlantic County CBOC (aka Northfield VA). He was then taken by helicopter to Temple University Hospital in Philadelphia where he later died.

IG's report revealed 11 health care failures linked to Ingram's death that included a failure to reach out to veterans needing mental health care who had not been seen in one year or more.

The Northfield, New Jersey location is new as of 2011.

At the time, VA moved the outpatient clinic to help improve access to services with upgraded technology and better care using the VA telemedicine platform. The facility was apparently created to utilize the cheaper but more technology dependent telemedicine model.

RELATED: VA Clinic Moves To Bigger, Better Facility In Northfield

However, reports circulated, and are now confirmed by VA OIG, that VA did not adequately staff the clinic, like elsewhere around the country.

As we now know, veterans seeking access to mental health care are reportedly not receiving the timely services the community was promised when the facility opened. And, unfortunately, at least one of them committed suicide by fire.

RELATED: Money Laundering Scheme Rips Off VA By $11M

Ingram reportedly waited longer than one month for appointments on a regular basis since 2011, when he started getting care at the Northfield VA facility. Prior to his death, he had not been seen for more than one year after repeated cancellations where follow-up appointment attempts were never made. VA did not reach out to him despite requirements to do so.

RELATED: VA Busted On Mental Health Failures

“We found no attempts to follow this process,” the inspector general said. Ingram died while waiting for VA to schedule non-VA health care from a mental health care provider. At the speed with which VA processes non-VA mental health care, Ingram would probably still be waiting.

“(S)taff failed to follow up on no-shows, clinic cancellations, termination of services, and Non-VA Care Coordination consults as required,” the inspector general wrote in a report released Wednesday. “This led to a lack of ordered (mental health) therapy and necessary medications… and may have contributed to his distress.”

RELATED: VA Reveals Apple iPad Program

Ingram was seen at the Northfield VA locate in New Jersey. Media was rather quiet about the suicide at the time, trying to manage political correctness while reporting on news America needs to know about.

As for the list of failures, here is my tally of the noteworthy failures from the IG summary:

1. failure to provide timely appointment
2. failure to follow overbooking instructions
3. failure to follow up after clinic cancels appointments
4. failure to follow up on patient no-shows
5. failure to provide follow-up appointments
6. failure to refill prescribed medications
7. failure to document lack of appointments
8. failure to acknowledge lack of appointments
9. failure to provide outreach to a veteran in distress
10. failure to schedule community care
11. failure to supervise clinic processes

After reading the report, I wonder how only one veteran committed suicide given the shoddy care VA dished out at the location. Numerous removals and reported terminations followed the suicide due to the colossal failures evidenced.

RELATED: Dirty Surgical Equipment Forces Cancellations

Sadly, while veterans face tragedy on the regular basis, the agency seems focused on maintaining its quest for political correctness, supporting transgender veteran awareness goals, all the while failing to provide safe and timely mental health services.

The patient was in his fifties when he completed suicide in 2016. He had been receiving VHA care for a variety of medical conditions, including obsessive-compulsive disorder (OCD) and a particular neurodevelopmental disorder (NDD). The patient received medical care intermittently at several VA hospitals since 1997. In 1997, the patient indicated he had been treated for depression in the past. His first VHA MH treatment began with management of OCD in 2000. At that time, the patient reported to the psychiatrist that he had been treated for the past 2 years by a non-VA therapist and a non-VA psychiatrist and had been taking fluvoxamine (Luvox®).

The patient continued on Luvox® and remained in psychiatric treatment. In 2005, he indicated that he was doing well and performing better at work with reduced compulsiveness. He attributed this

improvement to the medication Luvox®. During the visit in 2005, the psychiatrist continued treatment for OCD with Luvox®. At his next psychiatry visit in February 2008, he indicated he had run out of his medication and was experiencing increased OCD symptoms that were contributing to problems at work. For the remainder of 2008, the patient reported adherence in taking his medication and fewer symptoms.

In mid-2011, after a period of stressful life events, he had a MH Initial Assessment Consult with the Licensed Clinical Social Worker (LCSW) and began psychotherapy. During the initial session, the patient denied active thoughts of suicidal ideation. However, he stated that he had experienced suicidal ideation in the past with no history of a suicide attempt. He continued with ongoing individual therapy sessions until early 2013.

In 2012, according to the LCSW's clinical notes, the patient exhibited negative thought patterns that he attributed to his OCD. This created difficulty for him in maintaining personal relationships and employment. The LCSW also noted "Pt's mood and affect remains dysphoric [a mood of unhappiness]. He denies SI/HI [suicidal ideations/homicidal ideations], however, he admits to feeling hopeless at times. Thoughts were tangential but he responded to redirection, which was reinforced. Insight and judgment is limited." The patient attended several individual psychotherapy visits with the LCSW in 2012, then a final visit with the LCSW in early 2013.

A psychiatrist's note shows he started the patient on sertraline (Zoloft®) in early 2013, at which time his compliance with Luvox® was in question. In late 2013, the patient reported he was seeking care from a non-VA "therapist, and she is helping with ocd [sic]." He did not provide records for these visits. He noted that he wanted to keep his medications the same as his obsessive symptoms were reduced; he was sleeping better, and was calmer. He reported he felt his OCD was worse after stopping his medication and that he felt better after restarting it. In mid-2014, the patient provided a written outline of work history (dates, employers, and reasons for being terminated) to his psychiatrist. According to the psychiatrist, this large number of different types of jobs demonstrated "…a long extensive pattern of severe work impairment that is caused directly by his obsessive compulsive disorder [OCD] despite being [on] multiple medications and [seeing a] therapist… referring to a new therapist."

One month later, a VA psychologist assessed the patient for psychotherapy. She noted "DIAGNOSIS: OCD, will add new diagnosis of [neurodevelopmental disorder (NDD)]…Diagnosis of NDD due to patient's report of difficulties in social situations and rigid thinking patterns."

Two months later, the psychologist requested individual psychological testing to clarify the patient's diagnoses "between OCD and [NDD] or both. As well as treatment recommendations." While the psychology providers agreed his diagnosis was [a particular NDD], the psychiatrist disagreed and noted, "…this is classic ocd [sic]" and "… consistent with a diagnosis of obsessive-compulsive disorder [OCD], in my opinion."

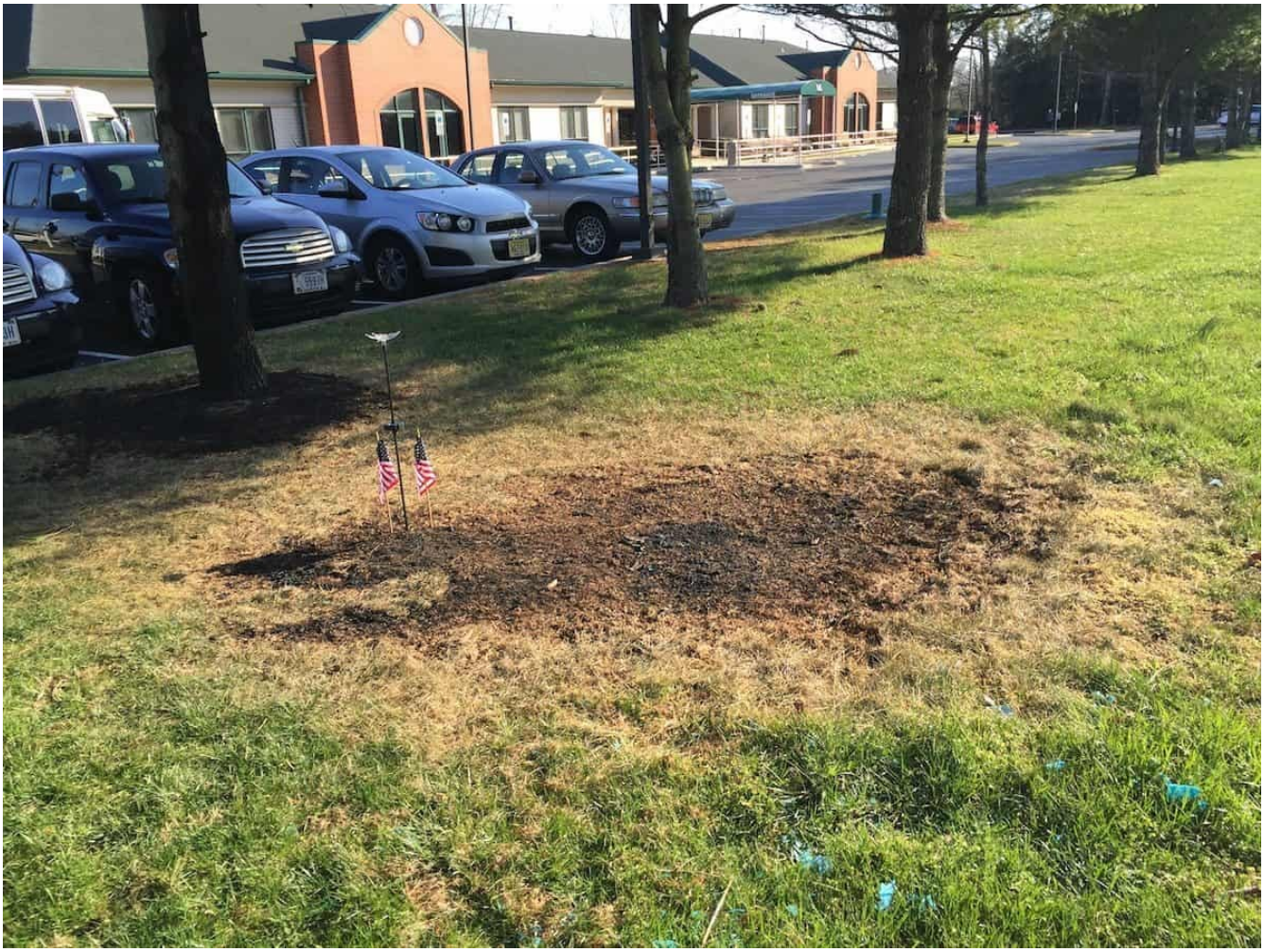
In early 2015, the psychologist saw the patient three times. During each of these 50-minute individual therapy visits for both of his diagnoses of a particular NDD and OCD, the patient denied suicidal and homicidal thoughts, plans, or ideation. He reported stress and frustration about financial and employment issues. According to the psychologist in early 2015, the patient's "thought process was

goal oriented with no evidence of thought disorder noted." He denied auditory or visual hallucinations, unusual experiences, special powers, etc. No contrary evidence was elicited during this interview." Orientation and memory "appeared intact for both long term and short term memory recall. He demonstrated fair insight and judgment." His prognoses during two of these three visits were documented as fair; his prognosis the following month was documented as guarded.

A specialist in the particular NDD was not available at the facility. In early 2015, the psychologist requested and received authorization for the patient to have several outpatient non-VA visits for his NDD. The non-VA provider, who had been contacted by the psychologist, told us the patient had not been seen despite the non-VA provider's attempts to schedule an appointment with the patient and telephone calls to the facility on more than one occasion.

Also in early 2015, at the request of the treating psychologist, the patient and his wife attended a 50-minute marital therapy appointment at the MH clinic with a marriage and family therapist. No other MH visits occurred in 2015 or 2016. However, the patient did seek medical and surgical care unrelated to his MH issues from other VA outpatient clinics during 2015 and early 2016. In late 2015, the patient walked in to the MH clinic to request an appointment with his therapist and, after speaking with the therapist briefly, was directed to a scheduling clerk who scheduled an appointment months later. The patient completed suicide before this scheduled appointment in 2016.

Source: https://www.va.gov/oig/pubs/VAOIG-16-03519-28.pdf



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Veteran Sets Self On Fire Outside Atlantic County CBOC

2 minutes

Police reported a veteran from New Jersey set himself on fire outside the Atlantic County CBOC operated by the Department of Veterans Affairs.

Atlantic County CBOC is a VA clinic in Northfield, NJ, and is part of the Wilmington VA Medical Center system.

The veteran, a man from Egg Harbor Township, apparently engaged in self-immolation by dowsing himself and then lighting himself on fire. He was then taken by helicopter to Temple University Hospital in Philadelphia. Little else is known about the incident.

Many readers may remember the Vietnamese Buddhist monk who engaged in self-immolation in 1963 to protest repression and abuse committed by the Vietnamese government.

Perhaps ***this veteran was doing the same!*** ?

VA has grossly failed its veterans when providing mental healthcare for those suffering from a variety of problems including suicide. Until the agency gets its act together, more veterans will likely suffering.

This instance of self-immolation will likely not be the last.

Source: https://www.courierpostonline.com/story/news/local/new-jersey/2016/03/20/nj-man-sets-himself-fire-critical-condition/82051718/

UPDATED: March 23, 2016 – The veteran who set himself on fire died days later.

Veteran Sets Self On Fire Outside Atlantic County CBOC
69 Comments / VA Healthcare / By Benjamin Krause

Atlantic County CBOC

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17343

69 thoughts on “Veteran Sets Self On Fire Outside Atlantic County CBOC”

dane roberts
November 9, 2016 at 2:52 am

Helpful piece . I was fascinated by the analysis , Does anyone know where I can get a fillable MI DoT 5107 document to edit ?

James
March 23, 2016 at 10:56 am

For repeat c&ps until they

James
March 23, 2016 at 10:54 am

The VA keep sending veterans

Jrsimone
March 22, 2016 at 8:26 pm

This happened right here at my hometown VA in the 70’s. Buffalo VA,.
I don’t think there is anything [political in these acts. These are guys just like Me and the rest of the 22 veterans a day that kill themselves. I have 4 immediate family members that did the same. He was hurting And the hurt is real. God Bless him,

namnibor
March 22, 2016 at 9:09 pm

Pretty sure the “Vietnam Political Protest Video” that Benjamin was using as part of the article was to serve as an analogy of state of desperate times, not any specific political agenda…just fraud and corruption and shitty healthcare.

The sad truth is that the VA has used the guise of “Veteran Suicide Prevention Programs” to receive loads of $$$ on more than a few occasions, yet I have personally had three Veteran friend’s die by their state of disrepair and craptastic healthcare in just last 5 years alone. This story will more than likely show very inconsistent care or the VA treating him for entirely the wrong thing or even a crapload of SSRI’s, that are known to cause Mania and more but combined with whatever else, not fun playing the human pin cushion to modern medicine to find what works.

Sometimes it takes a reminder of a Historical event such as this Vietnam Buddhist Protest Video, that literally sent shockwaves around the world, as a coupled analogy for this Veteran's plight with his health and the VA.

He specifically chose the outside parking lot outside that VA and could not be a mere coincidence.
Peace. This world needs more of it.

I did a search again using the same terms as yesterday, and an updated local news story shows that veteran has died.

No offense to Ben, but his blog post is the top link that comes up in the search, with maybe two or three other local news articles on this.

I can't find the words to describe how incredibly f%*cking disgusted I am over the lack of any news coverage of this.

I don't mean some ghoulish coverage, but news on it, or outrage from someone.

Some poor safe space seeking whiners at some college are offended by god in their cafeteria, and it's national news.

A veteran is filled with such despair over the lack of hope that he sets himself on fire, and it's f*+cking crickets in the media and from our politicians from coast to coast.

Whether he had pre-existing mental health issues over the past 30-40 years, he was still a veteran who deserved humane care.

trk
March 22, 2016 at 1:01 pm

Kind of sounds like this man…but idk. https://www.dailymail.co.uk/news/article-2913932/Was-Charles-Ingram-INNOCENT-New-book-reveals-unseen-evidence.html

Walt
March 22, 2016 at 8:36 am

And don't forget about the 32 year old Quaker (man) who in 1965 set himself on fire under Robert McNamara's window in protest of the Vietnam war … gone but not forgotten.

Jack
March 22, 2016 at 8:35 am

You comments about this vet are truly uninformed. We were friends for more than 40 years. This was not an act of protest as you suggest

"Many readers may remember the Vietnamese Buddhist monk who engaged in self-immolation in 1963 to protest repression and abuse committed by the Vietnamese government. Perhaps this veteran was doing the same?"

He had a history of mental health issues dating before his time in the Navy. This coupled with a difficult time personally likely lead to this tragedy.

Please respect this serviceman and do not use it as a platform for you political rantings.

Melvin
March 22, 2016 at 10:00 am

Jack,

Who are you directing your comments at.

You claim to have been a friend yet you then post embarrassing information no true friend would post. You also try to dismiss his actions as having no real meaning yet you then admit you don't know why he did it and offer a guess.

It is clear by your comments you were no friend to this Veteran.

To me this Veteran has sent a very loud and clear message about this VA Clinic where if he was receiving the help that he needed this would not have happened. So you will just have to accept the fact that I do care about this fellow Veteran and I am looking into this VA Clinic.

crazy elf
March 22, 2016 at 11:29 am

@Melvin
Very well said. As you so eloquently pointed out, "Jack" is not a real true friend to that veteran. For, IF he was, he would be trying to find out the reasons behind the: "WHO, WHAT and WHY" behind this "act of defiance" by a fellow veteran.
Therefore, I can only conclude, "Jack" is a 'troll' of the worst kind!
Melvin
March 22, 2016 at 11:56 am

Hey Elf,

While we are not certain that he is a troll yet, he certainly took the stance that we all have come to expect from the VA when speaking about this type of subject. Blame it all on the Veteran and try to shame anyone who is talking in support of the veteran.

Every thing in his post certainly does sound like he is a troll for the VA.
namnibor
March 22, 2016 at 4:23 pm

Definitely the Spring air has the unmistakable stank of Troll wafting in the air!!!

No true friend would remotely say what was stated, almost like the VA's stance, "OH…he had mental health issues BEFORE his Navy Service….", as to minimize it….indeed, the very worst kind of Troll, and also not exactly how a "True Friend" would respond.

Troll, until proven otherwise. Callous comments in past on here have shown exactly where they come from…within the cesspool of the VA Spin Machine Dr.
Melvin
March 21, 2016 at 11:43 pm

Susan Marie,

Thank You for bringing that point up. She is broad certified since 1992. Also as I pointed out that the boards website shows that "she is not meeting board MOC requirements", but it also points out that she does not need to meet MOC requirements to maintain her certification.

I hope that you can see as a disabled Veteran, who has been through the system, and now see that another Veteran has committed the act of setting himself on fire outside of the Clinic in NJ why I am looking into her Dr. Jane Chamberlain.

It is out of respect for this Veteran that drives me to find out why he did this to clearly draw attention to this VA Clinic in NJ.

What I am finding is very hard to understand. First in this 70-year-old, VA psychiatrist Dr. Jane Chamberlain, words about use of Telemedicine she stated "Picking up on a patient's nonverbal cues will be a little bit more difficult this way," Chamberlain said. "But it will allow us to be in multiple places at once. So we'll still get to see them, we'll still get to talk to them and we'll still get to treat them.". [1]

Next is the fact that her profile at the Wilmington VA Medical Center list her as licensed in 4 states California, Michigan, New Jersey and Pennsylvania. I can find no record of any license in California. Her license in Michigan is active until 1/31/2018 but list a private resident in New Jersey as where she practices. Her New Jersey license is active until 6/30/2017 and list her as working in West Palm Beach Florida as a Medical Examiner. Her Pennsylvania Medical License is active until 12/31/2016 although no address is listed for where she practices it does list the same city in New Jersey and zip code of the private residence listed on her Michigan License.

As pointed out regarding her certification in psychiatry where "she is not meeting board MOC requirements".

I have to ask where this 70-year-old medical examiner from West Palm Beach Florida, work from home physician, and psychiatrist who is not meeting board requirements was when this Veteran set himself on fire? Also I have to ask who is responsible for setting up this arrangement?

1. " New VA clinic in Northfield offers high-tech features, services for veterans"

"https://www.pressofatlanticcity.com/communities/northfield_linwood_somers-point/new-va-clinic-in-northfield-offers-high-tech-features-services/article_cb5ccfac-3a48-11e1-b57e-001871e3ce6c.html"

Melvin
March 22, 2016 at 12:55 am

For anyone following the post above was in response to an individual who responded to my post.

My earlier post was:

"After checking out more on the VA clinic in Northfield where this happened. It appears it's main function includes a Psychiatry clinic that uses Telemedicine with a Doctor in charge named Dr. Jane Mary Chamberlain.

When checking her info found something unusual. Although she is listed as certified it shows that she is not current with completing her Maintenance of Certificate (MOC).

The board list it as "MOC Status: Not Meeting MOC Requirements and Is Not Required To Do So".

Some kind of very special arrangement there given they are required to meet MOC every ten years.

So this is looking like another VA Programmed Suicide via prescription with a new twist. Telemedicine”

Susan Marie
March 22, 2016 at 7:26 am

It isn’t a special arrangement. Psychiatrists who were board certified prior to the early 1990s are not required to participate in the MOC process. I hold two board certifications. My first board certification, obtained in 1991, is permanent and I don’t have to participate in MOC for that reason. This is true of most certifications obtained prior to the early 1990s. That being said, I don’t endorse telemedicine and would not participate in it when I was a VA physician.

91Veteran
March 22, 2016 at 10:43 am

Thank you for rejecting telemedicine!!!

There are instances where telemedicine, Skype or other remote methods of treating patients is acceptable and even helpful for the patient, which should be the focus, and other instances where it is lunacy to think telemedicine is appropriate.

In the last years I was reviewing veterans medical research for funding, there were more and more research projects being pitched to determine the effectiveness of using telemedicine, and the bottom line reason was to cut costs. Quality of care for veterans didn’t seem to be much of a concern.

I am sure I am not alone in my opinion that telemedicine in some instances shows the doctor just does not care enough about the patient to bother with a face to face visit.

Why not just tell them to search out a few YouTube videos.

Melvin
March 22, 2016 at 11:45 am

Susan Marie,

Thank You for your informative reply and answering my questions on board certifications.

I still am seeing some kind of special arrangement and problems with that arrangement that likely contributed to, if not wholly caused, this Veteran to set himself on fire in front of that VA Clinic. Where if he had been receiving proper care this would not have happened.

To start with her FEC Disclosure Reports she lists herself as self-employed from 2012 on up to 2015. Her multiple active medical licenses list her as a Medical Examiner in West Palm Beach FL and several indicate that she is a work from home Doctor in New Jersey.

After numerous search the only work history findable on the web is that she has been connected with working as a Psychiatrist in several hospitals which specialize in adolescents and pediatrics before her taking the position at this clinic.

Add all of that to her age of 70+, her stated problems with getting use to the technology she had to use and the fact that she did not need to follow a Maintenance of Certificate Program. With the cornucopia of new drugs being used and tested at this time and also the new research in your field on

subject such as PTSD it would seem to me that a person working with Veterans should be required to be in a MOC program.

Have to wonder how many other Veterans are relying on this clinic for support that they may not be getting.

Also I would like to add that age may not be a factor here but we don't know since she was not in a MOC program. As you have pointed out that you hold several certifications one where like Dr. Chamberlain you are not required to be in a MOC program but the other I assume does require it and I am guessing you are near or approaching Dr. Chamberlain age and you have maintained both certifications proving age is not a factor in your case.

Susan Marie
March 22, 2016 at 12:15 pm

There are several components of MOC :

1) you must have a free and unrestricted medical license
2) you must have completed continuing medical education credits
3) you must take an exam which costs approximately 2000.00 and you must pay fees which can be several hundred dollars per year.

Most people with permanent board certificates complete 1 and 2 but not 3 due to cost.
VA requires 1 and 2 in order to be credentialed as a VA physician, so she has met 2 components of the MOC process simply by practicing at the VA and being credentialed by VA. She is not required to take the recertification exam or pay for it just as most physicians with permanent certificates do. There is nothing unusual about this.

Melvin
March 23, 2016 at 8:55 am

Susan Marie,

Although you imply in your comment that the VA require Physicians to meet the standard of having a free and unrestricted medical license and also must have completed continuing medical educational credits to maintain a certification with the VA.

Here in Minnesota we know for a fact that is simply not true. Thanks to the work of Ben Krause and KARE 11 investigative reporter AJ Lagoe. A prior blog article by Ben Krause and a report by investigation by AJ Lagoe prove that very clearly.

See:

"Veterans Affairs Caught Falsifying Doctors' Certifications"

KARE 11 investigative reporter AJ Lagoe and Benjamin Krause showing that the VA is actively falsifying Doctors Certifications and even after they were caught they did not remove the false certification information from their website.

"https://www.disabledveterans.org/2015/11/10/veterans-affairs-caught-falsifying-doctors-qualifications/"

“Medical credentials questioned at VA hospitals”

“https://www.kare11.com/news/medical-credentials-questioned-at-va-hospitals/11634411”

crazy elf
March 21, 2016 at 6:23 pm

My husband is a Vietnam vet that the VA treated for years (approx. 17)with zanax and hydrocodone, along with Prozac and seroqueol for PTSD. He was naturally addicted to both and in 2014 they told him he would no longer get it from the VA, to ween himself off or see private doctor? They created the problem, but absolutely no help with the results. So he went to private dr. and we had to pay out of pocket for their screw up, but worse 6 months ago they diagnosed a lung nodule benign ,even though his lymph nodes were lit up in CT scan. They said they would watch it? Now he has stage 4 lung and brain cancer, 23 brain leasions. We left the VA for private care, but his condition is terminal, what did the time they wasted cost my husband?? Why are they never accountable? We believed they would take good care of him, we were deadly wrong! Just like this poor mans family, God rest his soul, the VA is failing so many that served their country.

handcannon72vet
March 21, 2016 at 5:39 pm

I

I am sure there are plenty of VA vampire parasites, who could explain to you that this is all the fault of the vet. At about 70 years of age, I have yet to ever hear of the VA admitting to ANY fault in any tragedy or wrong doing. The first rule of VA employment is thou shall not admit error or sin.

Melvin
March 21, 2016 at 4:51 pm

So this is looking like another VA Programmed Suicide via prescription with a new twist. Telemedicine

Gretchen Saaduddin
March 21, 2016 at 5:23 pm

This is common place. They also rotate doctors who are trusted and well liked by vets to isolate the vet, never allowing them a comfort zone. They have actually forged my brother’s signature on documents. When I worked at a major university affiliated with the nearby VA, the doctors and residents studying at the university would make fun of the vets. That culture was supposed to have changed, but I don’t think so. They have classes with staff shrinks that teach the vets with PTSD that they are not responsible for ANY bad behavior, which leads to all sorts of acting out, when they should be taught how to safely work out frustrations, and become socialized. There is always a constant push to put vets on psych meds as well. Now they are pushing electroshock therapy (basically a lobotomy). I

think this is a study to test this procedure on the general public (for political protesters and the enlightened). The bottom line is feelings of hopelessness. It took my brother 40 years to get his disability. The VA has a joke meme..(DDD…Delay, Deny, until you Die. Very funny, don't you think? Sick VA Admin. bastards should hang.

James
March 21, 2016 at 5:53 pm

Took me forty years also
namnibor
March 21, 2016 at 5:35 pm

VA Telemedicine and Psychiatry…what could possibly go wrong? Or, as Melvin coyly implied, it sounds like Telemedicine and Psychiatry could easily take a page from one of my favorites, "The Manchurian Candidate" (1962),
""""https://en.wikipedia.org/wiki/The_Manchurian_Candidate_(1962_film)""""

Not stating that's what is going on but of ALL things, why have Psych Care Telemedicine and The VA be in the same room with these parasites simply furthering their freaky research…as Dr. Candy Man has shown, and the VA let it go on…and that was also Psych…person to person.

Will the VA's usual knee-jerk reaction be to have every one of us Vets wearing a Hannibal Lector Mask when on federal grounds? VA will then need another $3 Billion for Disney to market and manufacture said masks?

yeah, a bit flippant there, but that's the level of "ridiculousness" we have arrived at.
Susan Marie
March 21, 2016 at 6:18 pm

Its not the first time this has happened and it is a social protest. My father was a Bronze Star V device and Purple Heart Veteran who self immolated with Kerosene at Christmas 1995. It was no doubt a combination of my active deployments, HIS FIGHT WITH THE VA, and his TBI that drove him to that method. ***All self immolations are social protest by definition***. I would say half was his treatment from the VA. My dad was in the B2 501st Vietnam Class of 69-70 among the legendary Drive On that Johnny Cash sang about. About six years ago at Denver a Veteran of Vietnam did attempted to do it with lighter fluid but was put out burning 40% of his body. The last self immolation in Washington DC on Oct 4, 2013 was a veteran On July 14th of this year in Northeast Ohio A veteran tried again at a VA facility but was also put out. Below is a link to that story and any man who thinks I am telling fibs about my dad can go check his Unit;s website out. THIS IS MUCH MORE COMMON THAN PEOPLE KNOW! I was on active duty at the time to and that goddamn VA kept his disability back pay closing the estate while I was deployed abroad in Joint Endeavor! Worst part was a few years after death his case was one they used to change rules about disability back pay dying with the Veteran without spouse. Anyone can claim it by paying last expense or settling the estate within one year for the dead to my understanding now.

The VA and Government keep tight lips on the ones that die like my father and the guy on Oct 4, 2012 but when they survive you can find it in the internet everywhere, This guy OIF vet and we might never know his name because it sounds like he is going pass away. ALL self immolation deaths BY DEFINITION are Protest per Merian Webster Dictionary/ OH YEAH arguing with the VA how my dad

was treated and poor quality care got me a red flag just like Mr Krause and I can't see a MD without police escort and have a service connection. Below is link to OH story

https://www.10tv.com/content/stories/apexchange/2015/07/14/oh–va-clinic-suicide-try.html
James

Sad to see how little coverage this has gotten 2 days after it happened. Instead we have news of some nitwit prancing around Cuba, and saturation coverage of other nitwits acting like thugs.

The linked news article says he is 51 years old, which would likely make him a veteran of the Gulf War. I suspect he has fought the VA for years for health care of his illnesses from then, but the VA has ignored him and the law which should have made many of his health conditions service connected.

But hey, $172 billion for a budget should go a long way in paying the salaries and bonuses of those ignoring vets, and $22 billion for an IT contract should go a long ways towards ensuring any documentation of poor treatment is quickly lost.

I can see the VA working very hard right now on covering their ass, and sending him a bill for cleaning up their sidewalk.

namnibor
March 21, 2016 at 11:46 am

I have been thinking the exact same thing this weekend. Coverage of POTUS prancing around on tax-payer $$ hulling the "mother-in-law" AND kids to Cuba. Never mind Vets killing themselves and Vets being killed by,as POTUS likes to call them, "disenfranchised youth", and all the other 'nitwits' protesting.

Full moon and tonight's two-pieced green comet flying by Earth is taking it's toll on the lessor intelligence on this planet.

Think I need a wilderness vacation to just breath. This stuff can be overwhelming to underlying health issues. Seriously.

The VA will spin this unfortunate protest of this Vet somehow in order to vilify him, making the VA look squeaky clean. Just wait for it.

But then again, the VA may not even need to do so because I just had over three hours, three different MSM news feeds in background and not ONE PEEP about this Veteran's demonstration and hospitalization…not one. At least I have not run into it yet. Really a shame.

Going to start sending this story to many sources and suggest others do same to ensure it gets exposure. I am still breathing, so still fighting!

namnibor
March 21, 2016 at 11:48 am

Correction: "Haulng"…rather than 'hulling'.
crazy elf
March 21, 2016 at 12:58 pm

I agree! Watch VA try to villify the vet!

Wouldn't it be outstanding if he left a "suicide note" explaining the "WHY" of his act! In the note would be names, reasons and dates for this "act of demonstration!"

I'm not saying it was right, by no means. It just seems people do drastic things when they see no end in sight!

91Veteran

March 21, 2016 at 1:00 pm

It used to be that you would hear some politician making hay over something like this, but not hearing a peep shows how far this country has fallen when Congress is too lazy to say anything about this.

Over the years, if the WH was Republican, Democrats in Congress would attack the WH for not doing enough for veterans, if nothing more than to embarrass the WH, and veterans getting crumbs from whatever came of the attack. If a Democrat were in the WH, then the agency head was attacked so as to protect who was in the WH.

With this, there is nothing from both sides. No attacks, no claims of improper funding, no claims of incompetence…nothing.

It tells me two things.

1. Veterans have lost huge amounts of standing as a voting or influence group we may have had in getting Congress to act.

2. The major veterans organizations no longer care about doing what they were chartered by Congress to do…assist veterans. That should have been clear with the widespread VA scandals coming out over the past 3+ years, and the silence from veterans organizations in most if not all those scandals.

Hell I don't even remember any significant media coverage of ANY veterans organization expressing any outrage over 40 dead vets in Phoenix. In the past, 1 or 2 organizations might mount a sustained campaign at fixing something, with the 3rd or more groups unifying and getting legislation passed to fix a problem.

Now it's just silence.

Every one of them should have their charters revoked, along with the tax payer support they receive from Congress since they choose to ignore the primary reason they have a charter in the first place.

crazy elf

March 21, 2016 at 1:26 pm

@namnibor

A great deal of those "thugs" and "thugetts" which are causing all the trouble, (which are against Mr. Trump), are being bought and paid for by "SOROS", Sanders, Clinton and other "left wing sorry asswipes!"

I've read a few articles where Soros, and someone else, has an "International Warrent" out against him. How true I'm not sure. I'm still trying to confirm it!

Now, since the left is out "against Trump", and they are calling for his arrest. They all should be getting scared because there's starting to be a push against these "RIOTERS!" That's all they are – a bunch of punk ass idiots who are going to learn the hard way!

Here's just two of the many articles coming out from Saturday and Sunday! There's going to be more. Y'all can count on it! The "THUGS and THUGETTS" will lose!

Some woman who claims to be a "Commie" and more. Was arrested for "slapping a police horse" out in Kansas City. She's going to see some time lol! Stupid Bitch!

Up in Georgia, three little punks took a Trump sign out of a man's front yard. When the owner confronted them. One of them pulled a gun. Stupid move.
A neighbor saw the confrontation and came to his neighbors aid with his "legal weapon!"
To make a long story short. All three of the "THUGS" are in jail right now. Awaiting trial on "a slew of criminal charges!"

Wait for it. There's going to be lots more! People are getting pissed at these "left wing radicalized terrorists".

namnibor
March 21, 2016 at 5:11 pm

@crazyelf-

It's actually quite scary amazing how we Veterans, for the most part, are on the same 'thought frequency wave' and can have a clarity of what's going on in our USA and The VA. Yet, as 91veteran so precisely said, there's silence on both sides.

I will go as far to say that although the VA has been the federal agency train wreck for many, many moons and Wars and Conflicts; I will say that what was gained from The Cold War has quite literally fallen on deaf ears.

Never in my life would I have thought a POTUS would regularly announce what are active strategies and even troop counts were….on National and World TV. Our enemies have been popping popcorn for last 7.3 years of these 15 years of constant War. The only thing covert is career politicians making deals and horse and pony shows while Vets continue to be exposed to their Big Pharma Witch Dr. mentality.

Just over weekend or end of last week on Stars and Stripes, an article was on how Congress magically is pulling out of their magic hat that they sit on, a WHOLE NEW itemization of 'Presumptive Gulf War Svc. Connection', but further reading the article talked about how LONG the "actual" approval time and further studies…basically, the article went on to say those same movements through the Federal Bowels have sat like a snake that just ate a very large animal…from Vietnam, and how it will be at "end of lifespans for many"…and recall myself thinking, this is just like any or most large Insurance Companies where rather than pay out valid claims for 'damaged goods', the VA machine has an insatiable appetite for $$$, that it would rather give HUGE pay raises to VA Upper Management, than to pay out claims and just "Wait Until They Die", then repeat.
How much has some Boardroom already meticulously calculated, the Price of Freedom is? What's their established "liability limit", and why is there more accountability amongst a pack of rabid skunks, than the VA?

Does anyone else worry that this Veteran's Actions in today's article will somehow be buried and claimed by that thing they say when they have no other word for it…"The Fog Of War"? Never

mind the fact this Vet was obviously not getting appropriate care in order to feel that hopeless as well as helpless.

Is the VA more concerned about image than addressing finally, Veteran Suicide Prevention?
Benjamin, please keep us up to date if you can find more info on this Vet's situation.

Ran out.
Ron
March 21, 2016 at 3:48 pm

$22billion for IT!!!!!!!???????
Geezuz think what you could do with one tenth of that!!!!
Lets see, thats 2,200 millions….
And you get a pittance for. Service connected or AO deadly illness…
And no VA criminals ever go to jail, or even suffer any punishment!!!
Sharon Helman pleads to felony …gets probation!!
Hillary gets NOTHING!!
2 sets of rules and laws in America: Govt has no rules….the rest of us are watched like a hawk!!
And imprisoned at a level 100 times more!!!
91Veteran
March 21, 2016 at 4:09 pm

Ben had an earlier post on this looting of the Treasury disguised as a VA IT contract.
As I posted in that article, the Utah Data Center for the NSA cost $1.5 billion, with another $2-3 billion for hardware/software.
Makes me so happy every time I see the framed posters in the VA warning veterans about travel fraud. The last time I was at my VA, they had two posters outside the travel pay window, two in the primary care waiting area, two in the Lab waiting area and two in the xray waiting area.
Its as if the VAs entire $160+ billion budget is being eaten away by a bunch of thieving veterans.
crazy elf
March 21, 2016 at 10:46 am

Here's an article from, Military dot com, I received today. It's from yesterday 20 March 2016.
titled:
"Cruz, Cornyn, Abbott call for Accountability in VA Data Scandal"
by Jeremy Schwartz

It's full of doubtful (and possibly eronious) information from the VAOIG. In one paragraph, the OIG puts the blame totally on the schedulers for the "wait time scandal" to "improper training" and "lack of supervision"!

All I can say is; Give me a
fµ€king break! Because, for what 'reason(s)' do the schedulers (alone) have to "manipulate the books"?
"NONE!", would be my answer. The "order(s)" would have had to come from someone(s) higher up! The schedulers would have been taught HOW to manipulate the books.
Lastly, for what reason would these (lowly) schedulers have for manipulating the wait times? How about for "BONUSES!"
That's my theory!

James
March 21, 2016 at 1:40 pm

It’s all management doing this
James
March 21, 2016 at 10:11 am

Maybe they already flagged him
James
March 21, 2016 at 10:11 am

After they flag him
James
March 21, 2016 at 10:10 am

Once they transfer him
James
March 21, 2016 at 10:09 am

VA will finish the job
crazy elf
March 21, 2016 at 6:43 am

@namnibor and Robin,
I wonder what was going on in this veterans mind. To make him do such a thing?
We all know the upper echelon of VA won’t care one iota for this vet. They’ll say something about it, maybe. Then it’ll be “business as usual!”

_____

So sad for his family that he felt this was his last avenue to peace.

I am starting to think if you must kill yourself bring a friend…the one who made you do it. Buddies ride together.

Someone will eventually get the idea. Hell, even Irish IRA staving themselves and the Brits hated them got enough would attention they Brits have to change.

REPORT: Veteran Charles Ingram Suicide By Fire Linked To Massive VA Fails

38 Comments / VA Healthcare, VA Mental Health, VA OIG, Veteran Suicide / By Benjamin Krause

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Photo at Atlantic County CBOC of Charles Ingram burn site.

Northfield, NJ – VA OIG finally issued its report on the death of the veteran Charles Ingram, a veteran who lit himself on fire and later died.

Ingram, a veteran from Egg Harbor Township, engaged in self-immolation by dowsing himself with gasoline and then lighting himself on fire on one Saturday, in March 2016, in front of the Atlantic County CBOC (aka Northfield VA). He was then taken by helicopter to Temple University Hospital in Philadelphia where he later died.

IG's report revealed 11 health care failures linked to Ingram's death that included a failure to reach out to veterans needing mental health care who had not been seen in one year or more.

The Northfield, New Jersey location is new as of 2011.

At the time, VA moved the outpatient clinic to help improve access to services with upgraded technology and better care using the VA telemedicine platform. The facility was apparently created to utilize the cheaper but more technology dependent telemedicine model.

RELATED: VA Clinic Moves To Bigger, Better Facility In Northfield

However, reports circulated, and are now confirmed by VA OIG, that VA did not adequately staff the clinic, like elsewhere around the country.

As we now know, veterans seeking access to mental health care are reportedly not receiving the timely services the community was promised when the facility opened. And, unfortunately, at least one of them committed suicide by fire.

RELATED: Money Laundering Scheme Rips Off VA By $11M

Charles Ingram Suicide By Fire

Ingram reportedly waited longer than one month for appointments on a regular basis since 2011, when he started getting care at the Northfield VA facility. Prior to his death, he had not been seen for more than one year after repeated cancellations where follow-up appointment attempts were never made. VA did not reach out to him despite requirements to do so.

RELATED: VA Busted On Mental Health Failures

“We found no attempts to follow this process,” the inspector general said. Ingram died while waiting for VA to schedule non-VA health care from a mental health care provider. At the speed with which VA processes non-VA mental health care, Ingram would probably still be waiting.

“(S)taff failed to follow up on no-shows, clinic cancellations, termination of services, and Non-VA Care Coordination consults as required,” the inspector general wrote in a report released Wednesday. “This led to a lack of ordered (mental health) therapy and necessary medications… and may have contributed to his distress.”

RELATED: VA Reveals Apple iPad Program

Ingram was seen at the Northfield VA locate in New Jersey. Media was rather quiet about the suicide at the time, trying to manage political correctness while reporting on news America needs to know about.

As for the list of failures, here is my tally of the noteworthy failures from the IG summary:

1. failure to provide timely appointment
2. failure to follow overbooking instructions
3. failure to follow up after clinic cancels appointments
4. failure to follow up on patient no-shows
5. failure to provide follow-up appointments
6. failure to refill prescribed medications
7. failure to document lack of appointments
8. failure to acknowledge lack of appointments
9. failure to provide outreach to a veteran in distress
10. failure to schedule community care
11. failure to supervise clinic processes

After reading the report, I wonder how only one veteran committed suicide given the shoddy care VA dished out at the location. Numerous removals and reported terminations followed the suicide due to the colossal failures evidenced.

RELATED: Dirty Surgical Equipment Forces Cancellations

Sadly, while veterans face tragedy on the regular basis, the agency seems focused on maintaining its quest for political correctness, supporting transgender veteran awareness goals, all the while failing to provide safe and timely mental health services.

1012

IG Report – Charles Ingram Suicide By Fire

The patient was in his fifties when he completed suicide in 2016. He had been receiving VHA care for a variety of medical conditions, including obsessive-compulsive disorder (OCD) and a particular neurodevelopmental disorder (NDD). The patient received medical care intermittently at several VA hospitals since 1997. In 1997, the patient indicated he had been treated for depression in the past. His

first VHA MH treatment began with management of OCD in 2000. At that time, the patient reported to the psychiatrist that he had been treated for the past 2 years by a non-VA therapist and a non-VA psychiatrist and had been taking fluvoxamine (Luvox®).

The patient continued on Luvox® and remained in psychiatric treatment. In 2005, he indicated that he was doing well and performing better at work with reduced compulsiveness. He attributed this improvement to the medication Luvox®. During the visit in 2005, the psychiatrist continued treatment for OCD with Luvox®. At his next psychiatry visit in February 2008, he indicated he had run out of his medication and was experiencing increased OCD symptoms that were contributing to problems at work. For the remainder of 2008, the patient reported adherence in taking his medication and fewer symptoms.

In mid-2011, after a period of stressful life events, he had a MH Initial Assessment Consult with the Licensed Clinical Social Worker (LCSW) and began psychotherapy. During the initial session, the patient denied active thoughts of suicidal ideation. However, he stated that he had experienced suicidal ideation in the past with no history of a suicide attempt. He continued with ongoing individual therapy sessions until early 2013.

In 2012, according to the LCSW's clinical notes, the patient exhibited negative thought patterns that he attributed to his OCD. This created difficulty for him in maintaining personal relationships and employment. The LCSW also noted "Pt's mood and affect remains dysphoric [a mood of unhappiness]. He denies SI/HI [suicidal ideations/homicidal ideations], however, he admits to feeling hopeless at times. Thoughts were tangential but he responded to redirection, which was reinforced. Insight and judgment is limited." The patient attended several individual psychotherapy visits with the LCSW in 2012, then a final visit with the LCSW in early 2013.

A psychiatrist's note shows he started the patient on sertraline (Zoloft®) in early 2013, at which time his compliance with Luvox® was in question. In late 2013, the patient reported he was seeking care from a non-VA "therapist, and she is helping with ocd [sic]." He did not provide records for these visits. He noted that he wanted to keep his medications the same as his obsessive symptoms were reduced; he was sleeping better, and was calmer. He reported he felt his OCD was worse after stopping his medication and that he felt better after restarting it. In mid-2014, the patient provided a written outline of work history (dates, employers, and reasons for being terminated) to his psychiatrist. According to the psychiatrist, this large number of different types of jobs demonstrated "…a long extensive pattern of severe work impairment that is caused directly by his obsessive compulsive disorder [OCD] despite being [on] multiple medications and [seeing a] therapist… referring to a new therapist."

One month later, a VA psychologist assessed the patient for psychotherapy. She noted "DIAGNOSIS: OCD, will add new diagnosis of [neurodevelopmental disorder (NDD)]…Diagnosis of NDD due to patient's report of difficulties in social situations and rigid thinking patterns."

Two months later, the psychologist requested individual psychological testing to clarify the patient's diagnoses "between OCD and [NDD] or both. As well as treatment recommendations." While the psychology providers agreed his diagnosis was [a particular NDD], the psychiatrist disagreed and

noted, "…this is classic ocd [sic]" and "… consistent with a diagnosis of obsessive-compulsive disorder [OCD], in my opinion."

In early 2015, the psychologist saw the patient three times. During each of these 50-minute individual therapy visits for both of his diagnoses of a particular NDD and OCD, the patient denied suicidal and homicidal thoughts, plans, or ideation. He reported stress and frustration about financial and employment issues. According to the psychologist in early 2015, the patient's "thought process was goal oriented with no evidence of thought disorder noted." He denied auditory or visual hallucinations, unusual experiences, special powers, etc. No contrary evidence was elicited during this interview." Orientation and memory "appeared intact for both long term and short term memory recall. He demonstrated fair insight and judgment." His prognoses during two of these three visits were documented as fair; his prognosis the following month was documented as guarded.

A specialist in the particular NDD was not available at the facility. In early 2015, the psychologist requested and received authorization for the patient to have several outpatient non-VA visits for his NDD. The non-VA provider, who had been contacted by the psychologist, told us the patient had not been seen despite the non-VA provider's attempts to schedule an appointment with the patient and telephone calls to the facility on more than one occasion.

Also in early 2015, at the request of the treating psychologist, the patient and his wife attended a 50-minute marital therapy appointment at the MH clinic with a marriage and family therapist. No other MH visits occurred in 2015 or 2016. However, the patient did seek medical and surgical care unrelated to his MH issues from other VA outpatient clinics during 2015 and early 2016. In late 2015, the patient walked in to the MH clinic to request an appointment with his therapist and, after speaking with the therapist briefly, was directed to a scheduling clerk who scheduled an appointment months later. The patient completed suicide before this scheduled appointment in 2016.

Source: https://www.va.gov/oig/pubs/VAOIG-16-03519-28.pdf

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38 thoughts on “REPORT: Veteran Charles Ingram Suicide By Fire Linked To Massive VA Fails”

1. ***James Alto***
   November 20, 2017 at 5:41 am

   Too bad that the hospital isnt closer to where i live for i am not allowed to drive right now. But maybe T shirts can be worn with how to make napalm so a memorial & internal flame could be errected at the hospital

2. ***ted***
   November 17, 2017 at 2:30 pm

   we keep finding more problems yet the government cant even fix the problem. how do we start a veteran coalition?. this is going to get so bad in the future. as a veteran i see all other alternatives from the united states and senate is going to have to shut down the VA if another public epidemic of this is unresolved .if they dont its going to get violent .

3. ***ted***
   November 17, 2017 at 12:28 am

   FUCK THE VA

4. ***James Alto***
   November 16, 2017 at 10:55 pm

   I know what other vets have gone through for i was lied to, accused of liing, denied help, etc. and just had another Grand mal seizure and high blood pressure because of the Va,
   Every time i try to appeal an decision they give me an different answer even though i go through the Patient Advocate, next step is head of hospital, american disability association, then political if i live that long. For i over do but enjoy it st the vost of my health. Thank goodness for president Trump for he restored my right to own a weapon. I guess we will just have to restore to other means to receive what we are pomised . They even liec in Vietnam when they said they had no more troops in Cambodia. For we hadnt moved a foot so thry just changrd the border. I remember asking my CO. If we still grt combat pay for being in vietnam!

5. ***namnibor***
   November 16, 2017 at 9:46 pm

Off-Topic but Gov't screw-up that most of us can agree we saw it coming and here it unfortunately is: "[AMHERST, S.D. — TransCanada Corp.'s Keystone pipeline has been shut down after it leaked an estimated 210,000 gallons of oil in northeastern South Dakota, the company and state regulators reported Thursday…]" "https://www.msn.com/en-us/news/us/keystone-pipeline-leaks-over-200k-gallons-of-oil-in-south-dakota/ar-BBF3Qck?li=BBmkt5R&ocid=ientp"

6.

ThisVet2017
November 16, 2017 at 6:02 pm

Ok, so now that ww have an endless list of "failures", when is DOJ gonna file charges?

7.

Loren Farmer
November 16, 2017 at 4:17 pm

Rest in Peace you are now free of your pain my brother. What you did and how you did was horrific but your word or statement came through loud and clear. You are not the only get to feel the way you did. I am sorry for your loss as my brother but I am more happy that your pain and suffering has ended. Shame on you VA no one really believes you care.

8.

patrick moonan
November 16, 2017 at 1:49 pm

Delaware has the least funding for health care in the in the county. It receives about a 1000 per veteran less than the rest of VISN 4. Delaware has no inpatient care for mental health Veterans have to go to Coastville Pa 21/2hrs away.

9.

AirborneHoosier
November 16, 2017 at 11:35 am

Charles Ingram, a Gulf War Veteran, committed Seppuku (also called hara-kiri—ritual disembowelment) Self-immolation. To make a point. Selflessly Gave his life for one BIG reason. To shine a FIRERY LIGHT on the NEGLIGENCE of his fellow Veterans that the VA is ultimately accomplishing their goal of "a Dead Veteran is a good one". More money for them. What could be better? He ended his pains. The VA and MSM does not bring this to light, but Mr. Charles Ingram literally gave his life to bring light in the hopes that this system could someday be as efficient and squared away as ALL Veterans remember when they served Active Duty, because it was never operated by a paycheck. It was ran and operated for a laundry list of a Service Member's MORALS & BELIEFS. The VA is so far off from that and EVERYBODY knows it. BUT THEY JUST DONT FUK'N FIX IT.

#SurvivorGuilt #Neglected just another number. VA is broke. Somebody take charge. Please GOD, Recruit the Veterans that have Leadership and the Welfare of their Soldiers and the

accomplishment of the Mission always in the forefront and its NEVER NEVER EVER ABOUT MONEY & POWER & GREED. AN OATH, A VA TEAM MEMBER OATH.

The VA needs to be ran by ACTIVE DUTY MILITARY BRANCHES WHERE THERE IS ACCOUNTABILITY AMONG DOZENS OF VALUES FUCKING ABSENT FROM ALL THE FUCKTARDS CURRENTLY DUG IN AND GETTING WEALTHY OFF OF THIS BS SYSTEM.

RANT COMPLETE.

1. ***Warhorse***
   November 16, 2017 at 3:42 pm

   Airborne Hoosier, well said. Charles Ingram was a man, a Desert Storm Vet and a hero.

   Fuck VA, Fuck AFGE.

2. ***ThisVet2017***
   November 16, 2017 at 6:09 pm

   Who wouldn't feel hopeless here? The VA's atrocities are reported in the news, Congress passes laws, etc.. .and nothing changes.

   If a VA employee walked up to a veteran and shot the veteran in the head in the middle of the White House lawn, not only would that VA employee not be held accountable but OIG, MSPB, OSC, DOJ would find a way to whitewash the murder and the VA employee would be given a promotion to "Director" of some VA facility.

   Yes, and I'm not being sarcastic. Become a VA and/AFGE thug and the mafia would wet their pants when you walk through a door.

3. ***91Veteran***
   November 16, 2017 at 10:47 pm

   I hear what you are saying, AirborneHoosier, but as long as Shulkin pisses away billions on things like IT records management so some congressional crony can get rich, veterans will always get the short end of the stick.

   Imagine waiting a year for an appointment, and Ingram couldn't even get face time with a camera doc with their telemedicine bullshit.

   If he had a telemedicine appointment before, then had to wait over a year for another one, imagine how he thought about how much the VA cares for vets.

   Telemedicine that was sold as a way of providing timely care to veterans, particularly in rural areas.

It was nothing more than a way to claim a veteran got an appointment, a damn sight cheaper than seeing a human…so VA managers could direct that savings to boondoggles.

10.

james gallegos
November 16, 2017 at 11:29 am

I did not see PTSD as a diagnosis. Did they not give the PTSD diagnosis so they would not have to pay him and treated him for something different and never addressed the real issue.

Documentation or Progress notes if a veterans should get a copy and really look at these progress notes, you will see that many of these notes are repeated by each visit or by another provider such as social worker.

All most word for word. I did not see anything of this guys service was he in combat, did he receive a traumatic Brain Injury, was he denied disability for PTSD.

The VA as stated by the Secretary of Veterans Affairs, “The VA is very Adversarial towards veterans. Veterans suffering from PTSD, Traumatic Brain injury or other mental problems are nothing more that people who are Malingers, Fakers, and just want a disability to obtain Money.

This is the way too many employees think about veterans. These veterans have real problems and instead of treating them, they ignore the real problem and should the veteran shows any signs of disagreement with the treatment or treatment staff and say anything about them.

The veterans disability is not being considered, what the VA is doing is Accusing these veterans of Disruptive Behavior and Restricts the care they should be receiving and other VA employee start treating these veterans as being crazy and will belittle them or treat them as a threat and will Ignore them.

The VA is NOT for Veterans it is only for Employees and Employees come first !

If a VA employee harm a veteran and the veteran speaks up, the Veterans will be Ignored or Punished for speaking up. The VA Retaliates against any employee who tries to do the right thing and may be fired !

Veterans that try and do the right thing CAN NOT be fired, so what happens is the VA set up the Disruptive Committee to Punish veterans at will. I guess they think if they threaten Veterans with Federal Charges, Arrest and Banished from all VA care, will shut them up.

Not this veteran I will continue to Expose this Illegal Committee, who is acting as part of the United States Judiciary System, where they are being the Accuser, Prosecutor, Judge , Jury and Executioner. At the VA you are NOT innocent until proven Guilty, you are just Guilty !

Every right we are to have such as Freedom of Speech, Civil, Human and Constitutional Rights have been taken Away affording the Veterans to be able to face their accuser, or seek Counsel or a fair trial.

The VA has made the Veterans an Enemy and they are harming whom ever they want and no one seems to give to Cents if we veterans are being harmed.

Secretary Shulkin has ignored my Whistle Blowing against management Abuse or Abuse of Power.

1.

OHIO VA NEPOTISM
November 16, 2017 at 7:41 pm

James. Good point James.
1. Shooting from the hip. I would say. Most likely. The VA withheld “the PTSD injury diagnosis”, and then gave him some other bull sh*t disorder(s) or genetic bull sh*t disorder so they would not have to put(pay him) any badly needed money in his pocket…SO to ease up the stress already in his suffering life. Life falling apart and destroyed, he ended up having to work factory work (stressful employment), because he was too disturbed (injured from the military) to work in a professional atmosphere, or service related field as the nation has progressed towards.

2. Years ago, after WWII vets, and Vietnam soldiers (vets) could walk right off the battlefield (be discharged) and get a job in any one of a dozen factories near them. Lose your job, walk to the next factor next door.

3. Now our world has changed, now it is more competitive, professional, more education is needed in order to gain employment in our modern world (economy). A veteran and former soldier injuried and disabled with a disturbed (broken mind) is left behind. With NO factories left. No safety net for (VA rating money) the injured soldier (ptsd diagnosis) a veteran is left to the elements.

4. And then people and citizen and VA employees ask “WHY?” And they wonder why WE kill ourselves, live in poverty, go nutz, lose our wives, children, fail out of school, live alone, self destruct, and lose our jobs over and over again. And turn to alcohol and drugs, and end up in prison! And the people wonder why this happens to veterans and former soldiers. And they wonder “WHY?”

5. Thanx you VA Hospital staff and non veteran employees, and VA Benefits dept.

1.

namnibor
November 16, 2017 at 7:49 pm

Well said, VA Ohio Nepotism. That “Why?” seems such an easy answer from our vantage point yet so far far away from any VA mental health hack and NOW they think dishing-out the mental health via telemedicine, making it even further away and impersonal is better? I personally do not think the VA will ever ‘get-it’ regarding the Northern American veteran Species.

11.

Lem
November 16, 2017 at 10:30 am

And they didn't do a brain scan and EEG or a neuropsychological assessment! Hope this link copies!
"https://www.facebook.com/angela.owens.5074/posts/10213576741869749"

1.
Lem
November 16, 2017 at 10:32 am

At least I was able to copy from the above. Ben you need to do some work on this. Find out about the results of the brain section of the Las Vegas shooter.

12.
Seymore Klearly
November 16, 2017 at 9:58 am

Regarding Michael J. Missal: after reading the report issued by the VAOIG office on the investigation of the death of Charles Ingram. It is profoundly clear that Mr. Michael J. Missal need to be removed from the position of Veterans Affairs Investigator General immediately for the safety of Veterans who use VA Health Care.

The report is written with the sole purpose of covering up the names, policies, actions and laws broken that led to the death of Veteran Charles Ingram.

1.
CorpsmanUp!
November 16, 2017 at 11:13 am

Robin Aube is the culprit, and the OIG never named this director in the report, but she mysteriously moved on to NASA
"https://www.google.com/amp/amp.usatoday.com/story/93240026/"

1.
Crazy elf
November 16, 2017 at 12:42 pm

CorpsmanUp,
I'm confused by something. What kind of job (title) could a person, who had worked at VA, do at NASA!?
What would/could entice a person, from VA to NASA? Are they believing there's "easier pickings of taxpayers monies" at NASA?

See where my mind had wandered off to! "Following the money!" ???

2.
Oldmarine
November 16, 2017 at 1:13 pm

From a joke [VA] to a HOAX [NASA]
BUZZED up ARMSTRONG Is telling me to be Quiet so I got to run…To the green room, latter

3.

namnibor
November 16, 2017 at 2:45 pm

Wider hallways for the rats.

2.

Benjamin Krause
November 16, 2017 at 5:07 pm

I have heard from insiders that his report was a whitewash just like the Phoenix VA OIG report. Total joke.

13.

Crazy elf
November 16, 2017 at 7:11 am

Y'all are NOT going to believe this shit! Or, maybe you will!
From:
"Military.com/Daily News"
Dated:
15 Nov 2017
Titled:

"VA Seeks $782 Million for Electronic Health Records Overhaul"

"Stars and Stripes | Nikki Wentling

"Shithead Shulkin" wants the monies by the end of the year! VA is nothing more than a "black hole money pit" the majority of Americans have no knowledge about!
Oh, wait until you read what a Florida Democrat had to say about this FUBAR! And, WHO that Florida Democrat is [will astound you!]!!!!!!

1.

Oldmarine
November 16, 2017 at 7:27 am

"We have to do this quickly," he said. "The right thing to do is act with urgency, be aggressive and implement strict timelines."

Urgency LOL Couldn't do it before with billions spent on it must want a Christmas kickback from Cerner Corp…Nothing but a bunch of con men working at the VA… HANG THEM ALL IT'S THE RIGHT THING TO DO…We could save a lot of money before the NEW YEAR….LOL

1.

namnibor
November 16, 2017 at 7:44 am

Can we use bungee cord rope instead so we can watch and listen to them scream a few times and study the Doppler effect?

2.

Oldmarine
November 16, 2017 at 7:45 am

“Bringing VistA up to health industry standards would cost $19 billion over 10 years, Shulkin said.”

Your right ELF biggest black hole ever, The VA……That’s as bad as I need a new pair of boots because my shoestrings are broke…LOL

3.

namnibor
November 16, 2017 at 7:56 am

In 10 yrs the VA will have made 45 brand new systems that are not compatible with anything to ensure this train wreck keeps skidding sideways at terminal velocity.

4.

Oldmarine
November 16, 2017 at 1:45 pm

NASA has the brightest minds working on it.

2.

namnibor
November 16, 2017 at 7:30 am

And I’m pretty sure this has all happened before. IBM Watson was part of a multi-BILLION IT overhaul electronics records…and that black hole $$ replaced a few other prior electronic records overhauls attempts…anyone else see a pattern of flatulence?

1.

Oldmarine
November 19, 2017 at 6:53 am

They Retired Mr Watson he’s to old, Now they have the D-Wave computer it goes straight down to the ABYSS

14.

Peter Kreutzfeldt
November 16, 2017 at 7:10 am

if a horrific form of suicide does not capture the attention of the powers to be in the VA, I'm afraid nothing will

15.

Crazy elf
November 16, 2017 at 6:46 am

"FUCK THE VA AND AFGE!

Charles Ingram, and LOTS of other veterans, would still be alive IF those in charge: ie; "Shithead Shulkin" were to recommend or initiate a "purge" of ALL VA employees! Only, "Shithead Shulkin" is afraid of all the "bad publicity" it would generate!

We've seen this bullshit time and time again. VA employees generate poor healthcare, veterans are harmed or worse, and the perpetrators are transferred. Then, the same cycle begins again!

Shut down the VA. Allow ALL veterans to use outside healthcare! The amount needed, from the taxpayers, would be FAR less than it is now! Especially since VA has to "pay out" for the fuck-ups caused by its managements! That includes ALL the corruption, waste, fraud and abuse caused by its management and contractors!

16.

namnibor
November 16, 2017 at 6:10 am

When all bullshit fumes have cleared at end of the day, am betting the VA was more concerned about two things: 1) Public Affairs Image, and 2) Replacing ALL the ground's grass with asbestos-based Astroturf to prevent a future unsightly burn mark near employee parking…and wait for #3 when the assholes decide to install an "Eternal Flame" event marker right at that spot where Charles Ingram set himself on fire…with a VA CARES drinking fountain right next to it. Fuck The VA.

1.

James Alto
November 16, 2017 at 11:03 pm

Is that true snout the eternal flame? If so that is the straw that does it! They want to see an enternal flame? We do still know how to make napam! And maybe it will get out on how to even make it better as a flame thrower as we did in a compressed form shot put by the air hose from a truck. It eorked very well to get rid of vegetetion. And mixed with JP4 it was a sight to behold! I will have to find my photos from 50 years ago. For we wete told to be resourceful in developing new ways to disrupt the Ho Chi Mi. trail movement of arms and goods to the South. And we did !

17.

Oldmarine
November 16, 2017 at 5:53 am

” waiting for VA to schedule non-VA health care from a mental health care provider.”
Ha… It doesn’t have to be just mental health,It’s all outside care, Their schedulers don’t know what they are doing or their is not enough of them, Or better yet If the outside providers don’t get paid who the f$$k wants to work for nothing… I have been waiting to get a outside app. for about 4 months now they called about 2 weeks ago and left a message I called them up the next day and left a message, Still waiting what a joke…
But I do get outside care if it is important enough so this is just a test of their great care…LOL
Fuck you VA

1.
windguy
November 16, 2017 at 12:15 pm

I’m less inclined to blame nurses or doctors for scheduling outside care. They make the recommendations, and it goes into the abyss of Tri West/Care or other beltway bandits who troll the best deals and bill the VA double. Follow the money. Always, now more than ever, follow the money.

18.
CorpsmanUp!
November 16, 2017 at 5:03 am

Wilmington VA oversaw that clinic where bullshitter Carper. COONS AND Carney knew about a lot of things. This is the same facility that wrote in my medical record in which I presented evidence to DOJ, Hhs, OSC and the OIG. The director later got a job at NASA after this self – immolation event was reported in the news. OIG never does what they were meant to do and they need to stop embarrassing the law enforcement crest they wear.
Vince Kane who is in charge at Wilmington was caught interfering with an IG investigation in the past at another facility.
Goes to show you how full of shit Shuilkin is, when it comes to vetting and appointing Directors.
In keeping with good housekeeping and rollcall, “Fuck the VA” and all the canteen shopping, bow-legged,buffalo back ,big fat government employees that are dishonest!

VA Busted On Mental Health Care Numbers

Disability Rehab / By Benjamin Krause

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The Department of Veterans Affairs (VA) was called out yesterday by the Inspector General on the claim that 95% of its patients are evaluated for mental health problems and begin receiving treatment

within the 14-day goal. This is demonstrably false. In truth, only about half were evaluated within the two week window.

The VA Inspector General confirmed that only 64% are treated within 14 days, and the rest wait nearly six weeks on average before starting their treatment. The VA's "mental health performance data is not accurate or reliable," the inspector general concluded, adding that the department "overstated its success."

On the time it takes to begin treatment, the probe corroborated findings by a USA TODAY analysis published Nov. 9 which revealed that about a third of VA patients wait longer than 14 days to start treatment.

The Department of Veterans Affairs has reportedly backed off its own suicide report after reporters noted its own data revealed no change in suicide numbers and that suicides among troops were higher than expected.

Military Times noted VA was displeased that reporters and readers noted statistical outcomes it did not want. This year, the agency included breakdowns between various groupings of suicides. One of those groups is of active duty troops showing higher suicides than previously reported.

For 2015, the new numbers were 1,400 deaths, which is 900 higher than previously reported. Over the four-year span reported, the number of unreported deaths is over 3,400.

RELATED: Veterans Twice As Likely To Commit Suicide

Now, VA is backing off the report saying the numbers led to a "misperception" about the suicide numbers leading to "confusion" about military suicides.

VA Bumbles Response

According to the Military Times article:

"In our report, VA did not differentiate deaths between active duty, current never federally activated Guard and Reserve, and discharged never federally activated Guard and Reserve," said Dr. Keita Franklin, VA's national director of suicide prevention.

"This difference in the report may have caused some confusion and led to the misperception that approximately 1,000 more current service members died by suicide than DoD reported in 2015."

Franklin said including the breakdown in the report was designed to provide more information about the demographics of individuals who took their own lives. The updated report also contains new information on veterans' era of service, ethnicity and comparison age groups in an effort to provide "more data points for us to look at."

VA officials blamed the confusion on the troops' suicide information on inconsistent definitions used in various agencies. Individuals who served in the guard or reserves and are considered "veterans" in census reports may not have been counted in the Defense Department statistics because of different mobilization authorities and state rules.

But the VA researchers are now emphasizing they have not found fault with official military suicide statistics, which have counted between 550 and 450 active-duty, guard and reserve suicides in each of the last five calendar years.

What Report Did Show

The report still shows veteran suicides are holding steady at 20 per day despite record spending on vendor programs supporting the agency's goal to reduce suicides.

Tens of millions each year in spending on vendor projects to make suicide prevention programs look sexy has led to a zero decrease in suicide numbers. Imagine if VA spent that money on hiring psychologists to treat veterans?

Source: https://www.militarytimes.com/veterans/2018/06/25/va-backs-off-suicide-study-which-indicated-thousands-of-unreported-military-deaths/

Stay informed on VA news, scandals and benefits. Get our daily newsletter via email.

DisabledVeterans.org

Get our *free* daily newsletter.

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35 thoughts on "VA Catches Heat Over Previously Unreported Suicide Numbers In New Report"

1. ***TaB***
   June 26, 2018 at 7:14 pm

   I'm sadly reporting what I just heard on the news….That another veteran lit himself on fire at the Georgia Capitol building today.

These animals….

All they care about is making their pockets fat.

Where is our President? I seriously am upset about this.

2.

Dennis P
June 26, 2018 at 4:58 pm

I have to wonder about subliminal messaging where a word or phrase is repeated over and over to coerce someone to commit an act. I've heard it repeated and repeated again; are you thinking about harming yourself? Are you thinking about harming others? Are you planning on suicide or planning on harming others?….I think I see why veterans suicide rate is still so high!

1.

WyldeChylde
June 26, 2018 at 8:36 pm

They have to ask that. It's all CYA. Especially when so much of mental health care depends on self reporting. They have to be able to say that you reported no violent desires or else their culpable when you snap and shoot up a few employees.

3.

ANutterVet
June 26, 2018 at 2:40 pm

"https://prospect.org/blog/tapped/studies-show-private-sector-providers-are-not-ready-care-veterans"

1.

WyldeChylde
June 26, 2018 at 3:53 pm

I couldn't get through that article with a straight face. It's an apparent VA hit job and not even a very good one. I gotta say I find it hard to believe their numbers and, even if they are in fact true, I would posit that civilian health care is still, by orders of magnitude, far and away better than the VA can provide. It makes no sense to keep a corrupt and redundant agency afloat at the expense of taxpayer dollars and veteran lives.

They mention that the private sector is inadequate when it comes to treating mental illness. My rebuttal would be that the VA is completely inadequate for treating mental illness as is evidenced by the abundance of veteran suicides.

Honestly at this point RAND corp has got to be aware that they are seen as the VA's mouthpiece.

1.

ANutterVet
June 26, 2018 at 4:12 pm

I purposely put this article out to see what you and others would say. And, I don't know what side of the isle that this online mag in on. A lot of the information seem skewed to me too.

2.

WyldeChylde
June 26, 2018 at 4:29 pm

awww you mean I'm still loved??? 😉
get's me all flag wavey and shit 😀

3.

WyldeChylde
June 26, 2018 at 4:43 pm

One of the things that just occurs to me after smoking a bowl is that the article doesn't take into account the fact that in the private sector when a doctor fucks your life up they can be held accountable. As we all know accountability is anathema to the VA.

Let me put it another way. Can somebody ANYBODY chime in and tell me what conditions the VA treats so much better than a private sector doctor/specialist could? I truly would like to know.

I know some could argue that the VA understands PTSD and what soldiers who have it both combat and non combat endured and continue to endure as a result of this private hell. Personally I don't think anybody who wasn't at the scene of the crime so to speak could ever truly understand well enough what happened to each and every one of us. How could they? They weren't there. While there are definitely some short comings in the private sector mental health field I feel that the VA should be equally if not more so condemned at least on this particular point.

Also since the article tends towards pro VA and by extension AFGE membership I'm going to go ahead and say democrat. To me it sounds like an attempt to save union jobs. One of the areas I disagree strongly with the democratic party on. It is long past time to take the VA out behind the woodshed and put it out of our collective misery once and for all.

2.

James Clement
June 27, 2018 at 1:17 am

Bastids! Laughed so hard while reading that linked article that I spit iced tea all over my keyboard, seriously.

RAND = Rectal-brained And Negligent Doctors who have forgotten about everything except how to be a VA mouthpiece. And the average citizen eats this crap up.

Gotta do a “USA! USA!” (U Suck Assholes) for RAND.

4. ***Donald W Avant***
   June 26, 2018 at 1:15 pm

   Looking for a specific lie at the VA is like looking for a grey needle in s stack of black needles.through the wrong end of a spy glass…

5. ***lambda5555m***
   June 26, 2018 at 1:09 pm

   Maybe they should spend the money on the valid claims that Veterans have that get denied. Maybe that will lower the suicide and homelessness rates. They waste a lot of money doing stupid stuff and a way cool website is not going to make a difference in the larger scheme of things. Start approving claims instead of denying them will help more than all the other crap they are doing.

6. ***Don’t trust any group that gets paid***
   June 26, 2018 at 1:06 pm

   Does anyone have an opinion of AMVETS? They reached out to help.

   1. ***WyldeChylde***
      June 26, 2018 at 2:26 pm

      I’m not a big fan of any VSO organization. In my maybe not so humble opinion a VSO org is the Binder&Binder of the VA claim world. Organizations that are full of charlatans and snake oil salesmen that will promise you the moon if only you’ll agree to lifetime membership dues. VSO’s will very often horse trade your disability and when you dare question the decisions their making on your behalf via the power of attorney you have to sign. You get told to shut up and be grateful you’re even getting a fraction of what you should be getting. If you live in a state that has a veterans legal center then you should avail yourself of their resources. The best thing I ever did was fire the fucking useless cunts at DAV and got an attorney through my vets legal center. For free btw. My pitbull of an attorney is every bit as pissed off at the VA as I am over the delays in my case. She also knows what she’s talking about. My claim has been going on now for about 4.5 years. If I had stuck with the DAV I’d be sitting on a mountain of denial letters instead of successfully navigating the character of discharge phase due to an OTH discharge. Thanks to my attorney I am now waiting on a C&P exam date which should be coming down the pipe soon. If you can retain an attorney I STRONGLY advise you to do so.

      1. ***Don’t trust***

June 26, 2018 at 6:06 pm

They are helping with big problems with hospital and they contacted me to help. From headquarters, right now they have a nurse going through both my records and the hospital. They don't get anything out of it, just help. They seem sincere and knowledgeable, but sometimes free can quickly turn into a mess why asked. Thx

2.

WyldeChylde
June 26, 2018 at 8:27 pm

I've given you my opinion dude. I will also add that it doesn't hurt to also run it by an attorney. Kind of like a legal second opinion. Shouldn't cost you anything and may yield you some surprising results. You will find most people around here aren't very VSO friendly. An attorney that is free ie pro bono is still legally bound to represent you to the best of his/her abilities a VSO can look at you, shrug his shoulders, and say "Well gosh golly darn I sure as hell tried to get you what you deserved but the evil VA just won't budge. By the way can I interest you in a lifetime membership to a shitty bar with shittier beer?"

7.

Don't like to dance
June 26, 2018 at 1:01 pm

It is crazy on much they hide. Think it's a game that ends in death where win. I have learned so much about these shit bags and wished never did. The crisis line is trying to show how valuable the are, but there not. Don't know what people expect, it's the VA. I bet the whole report is wrong. I think number is close to 30 and that program is a waste of breath. There are other hotline and add 2 veterans to it them saving millions. They don't care and they probably spent 90 days to make reports using people that were the to help veterans and failed. I'm almost ready to the point where will be unable to walk in to the VA hospital because it sickens me. Problem is they know most people practicing outside and squeeze in just to ruin more shit. I can't believe how ignorant people are at the top, makes the ignorant people below to follow them in their Conga line of ignorance.

8.

Seymore Klearly
June 26, 2018 at 12:29 pm

NEW DETAILS: Disgruntled veteran sets himself on fire outside Georgia Capitol, GSP says,

NEW DETAILS: Disgruntled veteran sets himself on fire outside Georgia Capitol, GSP says
Updated 6 minutes ago
By Steve Burns and JOHN SPINK, The Atlanta Journal-Constitution

“https://www.ajc.com/news/crime–law/breaking-emergency-scene-outside-state-capitol/t1EJeInRLqB2fegT9JtLtI/”

“Disgruntled with the U.S. Veterans Administration, a veteran set himself on fire outside the state Capitol in downtown Atlanta on Tuesday, according to the Georgia State Patrol.

Shortly after 10:30 a.m., a Nissan Sentra parked on Washington Street along the west side of the Capitol, Georgia State Patrol Capt. Mark Perry told The Atlanta Journal-Constitution.

The veteran, a 58-year-old from Mableton, exited the car and walked across Washington Street toward the Capitol, according to officials.

“He was strapped with some homemade incendiary devices (and) firecrackers, and doused himself with some kind of flammable liquid,” Perry said.

Several loud explosions were heard. No shots were fired.

“That was the sound of fireworks,” Perry said.

A Capitol officer saw what was happening and put out the fire with an extinguisher, according to authorities.

The veteran was rushed to Grady Memorial Hospital with burns over 85 to 90 percent of his body.”

1. ***Seymore Klearly***
   June 26, 2018 at 12:42 pm

   “https://twitter.com/twitter/statuses/1011636400578596865”

   1. ***Windguy***
      June 26, 2018 at 1:09 pm

      Love the labeling .. “Disgruntled Veteran” That’s like saying a suicide bomber is philosophically and theologically conflicted with his victims. Heaven forbid we portray our veterans as depressed, desperate and suicidal. We need better optics for having made the VA great again, and again, and again.

2. ***Seymore Klearly***
   June 26, 2018 at 12:48 pm

   Veteran protesting VA sets himself on fire outside Georgia Capitol
   By Max Greenwood, The Hill – 06/26/18 12:06 PM EDT

   “A veteran set himself on fire outside the Georgia state capitol in Atlanta on Tuesday after he launched a “personal protest” against the Department of Veterans Affairs, the Georgia State Patrol said.

“A veteran that was disgruntled with the VA did a personal protest in front of the capitol, which involved gasoline and some fireworks and he was injured,” Mark McDonough, the commissioner of the Georgia Department of Safety, told WSB-TV in Atlanta.”

“https://twitter.com/twitter/statuses/1011628792857743360”

“https://thehill.com/blogs/blog-briefing-room/news/394179-disgruntled-veteran-sets-himself-on-fire-outside-georgia”

1.

Seymore Klearly
June 26, 2018 at 12:55 pm

The comment section of the Hill article is full of anti-Veteran pro-genderbending bullshit. Also full of liberals calling for gun control to prevent Veterans from owning guns.

Some seriously twisted individuals.

2.

namnibor
June 26, 2018 at 5:20 pm

Fuck!!!!!!!!!!

3.

T
June 27, 2018 at 5:08 am

That comment section and remarks are what I live in and with daily in my area…. and worse. Man gets killed here and depending on who they are may not be on the news. They “don’t report all deaths or fatalities” is the excuse. Ha.

How many vets or people ya know has gone as far to stick large signs in their truck bed complaining about local corruption at the VA and local hospital about covering up for VA damages and treatment to the civvy hospital and clinic staff refusing to give me copies of my med files from them? And is supported by the lefty college town community, et al. And no media will touch my story. Kind shows how Indiana is doesn’t it? They have had a jump on Maxine Waters’ shit for years now along with other games and tactics used my the powers that be here. Oh and seemingly is state and federally protected and supported.

People tend to not believe that there is a real war going on against men, white men, vets (all), non-Democrats, or anyone who dares question any form of corruption, the censoring, or trying to get some attention to all the thuggery down right insanity.

9.

Lem

June 26, 2018 at 11:11 am

The call center has responsibility without authority. No matter what the call recipient thinks is the likely hood that the caller will commit suicide after she hangs up or the caller hangs up on the recipient of the call the recipient cannot get the veteran into a neurobehavioral unit and if the caller gets themselves in, it will be for a max of a 3 day observation. Not enough time for someone really dealing with something. And the treatment is a one size fits all like the current PTSD group therapy program that is going around.

While that may cover up to half of the group the others are being left to their own devices which often means that finale exit because they can't cope. And I believe most of those have an organic problem which is never addressed.

"https://video.genfk.com/283984572006650"

10.

WyldeChylde
June 26, 2018 at 10:03 am

I've said this before. When Vets start taking asshole employees with them ala Albert Wong then this statistic will be straightened out overnight.

We as vets have been at war with the VA for quite some time now. This war has been declared on us by malfeasance and malpractice by incompetence and corruption by cronyism and nepotism. Frankly I'm amazed that more VA employees aren't dropping dead from acute lead poisoning. This needs to be fixed. Once employees realize that AFGE membership doesn't make them bullet proof perhaps then MAYBE we can straighten out the VA.

DHS/JTTF DON'T. FUCKING. BOTHER.

11.

march hare
June 26, 2018 at 9:21 am

Tens of millions on vendor programs, trinkets, and a faulty suicide prevention hotline, and none for good qualified psychologists and psychiatrists. In my many years of dealing with the VA, I've only met two that actually care and are supremely qualified. What I'm trying to say is talking to an incompetent psychologist ore psychiatrist can be worse than not seeing one at all. I live in a rural area, I go to a small outpatient clinic once a month in some hospital, we have a lot of vets in the area in need, the VA will not give us/them the room needed to expand, they've been dragging there feet for years, it's just pitiful, even when there are good qualified personnel, the VA can't find the funding to keep the lights on an extra hour a month. I have my own theory about that and that is they do not want us to organize and communicate in any cohesive and constructive manor. A good deal of the problem with mental illness is isolation and in more way than one the VA will try to isolate. To the VA I'm just another dumb grunt, I get that, but their underestimation maybe to my benefit. And as always fuck the Lebanon VAMC, you worthless pieces of dirt, put on your white velvet gloves and go stand in the corner fuck yourself.

12.

namnibor

June 26, 2018 at 9:03 am

Anyone ponder what that ‘urgency’ would be if among the AFGE Minions at the VA, they suddenly had 22+ suicides a day?
The AFGE would of course, connect the crazy dots to we Vets being the cause and effect of their suicides.

With ^that^ said, would it not make as much sense that most Veteran Suicides cause and effect are in-fact the VA itself?

Eliminate the indifferent assholes holding the suicide prevention carrots= Problem solved.

13.

ANutterVet

June 26, 2018 at 8:56 am

Until there’s urgency, can’t apply hope in VA.

14.

L

June 26, 2018 at 6:32 am

VA BUMBLES RESPONSE? Seriously???? VA LIES. Bottom line. The only thing they are truly guilty of, killing Veterans and not calling it Murder/Suicide secondary to the lack of care, respect, dignity that we Veterans have earned. What is exposed is only the tip of the ice berg. Even when the Media exposes these atrocities, there is a 15 second buzz and then snuffed out. My family voted for President Trump to make things better, now if there was an impeachment Roster, they would sign it. All Congress has done is give more money to a System that will never be fixed, and will never be there for us Veterans. Statistics don’t lie, no matter how slanted you translate those numbers.

1.

T

June 27, 2018 at 4:53 am

The tip of the iceberg is correct… the very teeny tiny tip exposed that is. IF that depending on region or state.

More studies? Odd I have explained to many of them what the problems are and like they all don’t know… how corrupt this area and state is.
Sen Todd Young email news update:
“Protecting our Veterans
Suicide is one of the most serious problems facing our veterans today. On Wednesday, I spoke on the Senate floor to share my efforts with Senator Donnelly and Congressman Banks to ensure our veterans receive the highest quality of care and support they deserve. Our amendment based on our original legislation would study the effectiveness

of the Veterans Crisis Line and the follow-up treatment these veterans receive. Studying the crisis line is vital to ensure that it is successful in its mission: to save as many veterans as we can. ”

Oh oh, more excuses for censoring, merging, corrupt corporate controls, news will be more hard found.
“https://indianapublicmedia.org/news/indiana-newspapers-limbo-media-merger-150591/”

Killem’ with water:
“https://federalnewsradio.com/dod-personnel-notebook/2018/06/chemicals-used-by-military-contaminate-drinking-water-cause-serious-health-issues/”

15.

Don Karg
June 26, 2018 at 3:53 am

06/26/2018

Dear Benjamin Krause,

“Suicide prevention is VA’s highest clinical priority”

How quickly the VA has forgotten about their enterprises that never picked up the phones [suicide hotline].

Sincerely,

Don Karg

16.

Fred
June 26, 2018 at 1:33 am

What do they care…they already got their funding that will go to politicians and friends contracts..is the only reason that the VA exists…or did you think they were there to help vets?? hahahahahahha

1.

cj ¯̿̿̿̿’’’’̲̲̅̅)̲̲̅̅ ‘̲̲̅̅╦̲̲̅̅=(•̀.̫•́)=o̲̲̅̅Ƶ̲̲̅̅’̿̿̿̿
June 26, 2018 at 2:20 am

I hear ya Fred, and it’s been proven over and over, and over again my friend.

2.

march hare
June 26, 2018 at 6:58 am

Thanks Fred, had me laughing this morning, The vA is bizarre that’s for sure.

3.

Longfellow Ragoczy
June 26, 2018 at 10:44 am

Fred, you absolutely correct.
Each dept. within the VA is only concerned about how they are viewed by the higher ups. They will do whatever it takes to shine in Wash DC and the publics eye. These compartmentalized VA depts. will even commit FRAUD at the behest of the VAMC directors' behest. I've seen it done time and time again. It needs to STOP!